MENTAL HEALTH COALITION
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Executive Summary

1. Introduction

In recent years, a number of problems have been identified in the CRD mental health system of care. Within the current system, no mechanism exists for determining mental health goals and priorities for the entire community; nor is there a comprehensive management and clinical information system which would permit mutual access to vital clinical information by the major service providers and the determination of measurable health care outcomes.

With estimated annual expenditures of approximately $29 million for mental health services in the CRD, system-wide planning and resource allocation has become a critical need. The establishment of a Mental Health Coalition is an integral step in addressing this need.

In February, 1992 a Steering Committee was appointed under the auspices of the Victoria Health Project, and funded by Mental Health Services, Ministry of Health to begin the process of forming a Mental Health Coalition which would, when established, report to the Capital Health Council. The urgency of some of the issues regarding mental health, and the extensive consultation time required prior to the establishment of a Mental Health Coalition dictated that this process commence prior to the formal establishment of the Capital Health Council. The firm of **Tedlie Clark Management Group** was selected to facilitate the establishment of this Coalition.

Six initial members to the Capital Health Council were appointed by the Minister of Health in March, 1992. In May, 1992 responsibility for the formation of the Mental Health Coalition transferred from the initial Steering Committee to the Capital Health Council. This Report marks the conclusion of Phase I of the Mental Health Coalition Project and includes the results of an extensive consultation process. Phase II of the project will include the selection of the Mental Health Coalition members and the establishment of the Coalition's operational mechanisms and relationship with the Capital Health Council and the community.

2. Project Approach

The goal of the Mental Health Coalition Project is "to establish a Mental Health Coalition to develop a management structure for the coordinated operation of a mental health service in the Capital Regional District."

The Mental Health Coalition Project consists of two phases:

Phase I: In consultation with the initial Steering Committee, and later with the Capital Health Council, to undertake an extensive community consultation process to determine a consensus on the composition and tasks of the Mental Health Coalition. Phase I also included an extensive literature search on alternative models for the management of mental health services.

Phase II: To select the initial members to the Mental Health Coalition and to facilitate the development of a management structure for the coordinated operation of a mental health service in the CRD.

3. Coalition Focus

The Mental Health Coalition will bring together the key interests concerned with mental health in the Capital Regional District. Under the direction of the Capital Health Council, it will assist in fostering comprehensive, continuous and coordinated delivery of mental health services.

The Coalition will provide a focus on mental health needs centred around issues drawn from the perspective of the whole community, rather than individual provider groups. It is intended that it will provide direct community access and input from a broad base of consumers, providers and practitioners, building on existing community networks. The Coalition will develop consensus around key mental health issues, identify priorities and develop action plans. It will coordinate with other coalitions where overlapping concerns are identified.

4. Community Identified Needs and Suggestions

During Phase I of the project, consultations with the community identified a great many mental health issues and problems, generating many suggestions on desirable objectives and tasks for the Mental Health Coalition. Some identified problems were specific to one group or individual. However, over the course of the consultation process, it became evident that the problems and issues identified by the community fell within several broad categories:

A. Scope

Many felt that the scope of the Mental Health Coalition's attention should be as broad as possible, from prevention to care for the chronically mentally ill. At the same time, there was strong support for the idea that the Coalition, while working within a wide scope, should have a clear focus on the needs of the chronically and seriously mentally ill, including those suffering from schizophrenia, manic depressive illness, Alzheimers and dementia. Advocacy systems were also identified as being of great importance for the chronically and seriously mentally ill.

B. Coordination

All institutional and community groups saw the need for the Mental Health Coalition to play a strong role in the coordination of services within the community. There were many references to little or no coordination in the present system, and where it does exist, it is often dependent on informal relationships among individuals.

C. Comprehensive Services

Closely related to coordination, the community indicated a desire that the Mental Health Coalition be involved in planning for comprehensive services within the CRD. Deinstitutionalization has brought into clear focus the lack of comprehensive community services. Areas mentioned as being particularly lacking at the present time include:

1. Adequate community based housing for the mentally ill.
2. Community based emergency services offered on a 24 hour per day, seven day per week basis.
3. Affordable treatment options.

While there were many other examples of a lack of services, those above were the three that arose in almost all discussions.

D. Continuity of Care

Closely related to both coordination and comprehensive services is continuity of care. In fact continuity of care is dependent on both the successful coordination of the client's treatment, and the availability of the necessary resources to allow for continuity.

E. System Evaluation

Many individuals and groups pressed for a thorough evaluation of all services presently available in the CRD related to mental health, including institutions, mental health centres and community agencies and groups. Many felt that it was not enough to simply look for additional funds to try to deal with the provision of comprehensive services.

F. Funding and Resource Issues

While most individuals and community groups were anxious to see the Mental Health Coalition become involved in recommending on funding issues, this was tied closely to the concerns around evaluation. That is, the community does not want to see the Coalition simply given some input over additional funds without a corresponding thorough evaluation of the cost effectiveness of the current system.

G. Policy Planning

It was suggested that while important that the Coalition concentrate on service provision issues, it is also important that the Coalition become involved in policy planning. Without the right policies in place to support the provision of services, efforts at coordination, comprehensiveness and continuity will not be successful.

H. Bureaucracies

There was a clear warning from the community during the consultation process that the Capital Health Council and Mental Health Coalition must not be simply "add-on" bureaucracies which would add another layer for those individuals or groups who were seeking program support, funding approval or problem resolution.

I. Community Input

There was consensus on the need for adequate and regular community input to the planning, funding and delivery of mental health services if the efforts of the Mental Health Coalition to implement some of the above improvements are to be successful. Many individuals and groups stressed that it was important to let the community become part of the solution.

The Capital Health Council, with the advice of the Mental Health Coalition is presented with the task of designing a mental health system that can live up to the promises of community-based treatment.

A realistic and workable model, incorporating both innovation and flexibility, must be developed for the delivery of comprehensive and coordinated mental health services in the CRD.

5. Alternative Coordination Models

Ultimately, local community considerations will determine the mechanism which will be implemented for the coordination of mental health care in the Capital Regional District. There are, however, essentially four different structural models which have been reviewed in the literature around which communities have built a coordinating mechanism for mental health. The entrepreneurial model, the current "structure" in place in the CRD relies on informal and ad hoc relationships to achieve minimal levels of coordination. The coalitional model provides a loose, voluntary structure, but with a moderate level of commitment to the coordination effort expected of system participants. The federative model utilizes a mandated structure with formal agreements defining participants' respective roles and responsibilities; final decision-making power rests with the individual organizations. The integrative model employs a formal, mandated structure to coordinate system activities; the central mechanism has the authority to make binding decisions with respect to inter-organizational disputes.

In initiating any model of coordinated services, 12 basic components are essential to successful implementation: 1) a central authority; 2) cultural relevance and specificity; 3) strong leadership; 4) a multidisciplinary approach; 5) multiple patterns of communication; 6) case management and continuity of care; 7) chronic patients targeted; 8) training and education; 9) community orientation; 10) flexible funding arrangements; 11) accountability mechanism; and 12) evaluation.

There are two overriding concerns that must be taken into account prior to implementing a coordinated system of mental health services. First, those who will be affected must be involved in the planning process. Secondly, it will take time to bring organizations into a new type of relationship. Other barriers to implementation include administrative, professional, economic, political and legal barriers. While each barrier seems formidable, none are insurmountable.

Ultimately, quality community care for the mentally ill will depend on a response from the greater community which supports and reflects an understanding of and genuine concern for the anguish and promise of mental illness. Negative stereotypes of mentally ill persons must be overcome by realistic portraits of the mentally ill person as a unique human being with unique needs.

6. Conclusion

It has been said by one member of the mental health community that "sometimes splendid opportunities come cleverly disguised as insoluble problems."[1] The Capital Health Council is currently faced with what may seem to be a momentous task, but the opportunity is great for real transformation of the mental health care system in the CRD. The emerging Mental Health Coalition has immense potential to mobilize the community around the many and diverse needs of the mentally ill.

For a coordinated mental health system to work effectively, all components of the system must work in tandem toward the common goal of ensuring the well-being of each mentally ill individual and preventing such illness whenever possible. Mandated or not, such cooperation cannot ensue unless there is a spirit of unity and a willingness to take risks.

1. Introduction

Mental Health services in the CRD are provided through a range of institutional and community-based programs and services. The primary providers of institutional care are Eric Martin Pavilion (EMP) of the Greater Victoria Hospital Society and Jack Ledger House of the Arbutus Society. The primary providers of community-based care are the three Mental Health Centres, and a range of funded agencies providing housing, vocational, social/recreation, advocacy and self-help services.

In recent years, a number of problems have been identified in the CRD mental health system of care. Within the current system, no mechanism exists for determining mental health goals and priorities for the entire community; nor is there a comprehensive management and clinical information system which would permit mutual access to vital clinical information by the major service providers and the determination of measurable health care outcomes.

Over time, this absence of system goals, information linkages and measurable health outcomes has resulted in:

- fragmented program/service development complicated by service gaps and duplications, and
- unhealthy competition among provider organizations resulting in inappropriate allocation of limited mental health resources.

With estimated annual expenditures of approximately $29 million for mental health services in the CRD, system-wide planning and resource allocation has become a critical need. The establishment of a Mental Health Coalition is an integral step in addressing this need.

In February, 1992 a Steering Committee was appointed under the auspices of the Victoria Health Project, and funded by Mental Health Services, Ministry of Health to begin the process of forming a Mental Health Coalition which would, when established, report to the Capital Health Council. The urgency of some of the issues regarding mental health, and the extensive consultation time required prior to the establishment of a Mental Health Coalition dictated that this process commence prior to the formal establishment of the Capital Health Council. The firm of **Tedlie Clark Management Group** was selected to facilitate the establishment of this Coalition.

Six initial members to the Capital Health Council were appointed by the Minister of Health in March, 1992. In May, 1992 responsibility for the formation of the Mental Health Coalition transferred from the initial Steering Committee to the Capital Health Council. This Report marks the conclusion of Phase I of the Mental Health Coalition Project and includes the results of an extensive consultation process. Phase II of the project will include the selection of the Mental Health Coalition members and the establishment of the Coalition's operational mechanisms and relationship with the Capital Health Council and the community.

2. Project Approach

The goal of the Mental Health Coalition Project was "to establish a Mental Health Coalition to develop a management structure for the coordinated operation of a mental health service in the Capital Regional District."

The Mental Health Coalition Project consists of two phases:

Phase I: In consultation with the initial Steering Committee, and later with the Capital Health Council, to undertake an extensive community consultation process to determine a consensus on the composition and tasks of the Mental Health Coalition. Phase I also included an extensive literature search on alternative models for the management of mental health services.

Beginning in February, 1992, and extending through May, 1992, an extensive consultation process was undertaken with groups and individuals in the Capital Regional District having an interest in mental health issues. Interviews and meetings included staff from the Greater Victoria Hospital Society, the Ministry of Health and Mental Health Centres, the Capital Regional District, and a broad range of community care providers and advisory and support groups. (See Appendix A for a list of the community agencies and groups consulted.) In addition, many interested individuals who were not on the interview list or at the meetings telephoned members of the project team with suggestions and advice.

The focus of the meetings was to gather input and advice from the community on the establishment of a Mental Health Coalition. Topics covered during the consultations included the size and membership of the Coalition, the mandate and objectives, and key issues which the Coalition should address as a priority. The meetings also generated considerable information on present shortcomings of the mental health delivery system in the CRD.

While there were many meetings with individuals and community agencies during the consultation process, considerable additional effort is required to develop communication links with the Aboriginal communities in the Capital Regional District. In addition, consultations with Health and Welfare Canada will be required regarding funding issues concerned with the provision of health services to Aboriginal people living within the CRD.

Two public meetings were also held during the consultation process. An initial meeting in March was called to familiarize the community with the Project and its purposes and to begin the dialogue around priority mental health issues in the CRD.

A second public meeting was held in May, attended by more than 170 individuals. At the meeting, feedback was provided on the major issues identified during the consultations and the process which would be used to create the Mental Health Coalition.

This Report marks the conclusion of Phase I of the Project.

Phase II: To select the initial members to the Mental Health Coalition and to facilitate the development of a management structure for the coordinated operation of a mental health service in the CRD.

Following the public meeting in May, an advertisement was placed in newspapers th. ughout the Capital Regional District inviting applications and nominations for the Coalition. Although the

deadline for submissions was stated as June 30, applications were accepted during July as well. More than 40 applications and nominations were received. From these, an initial Coalition of approximately 16 members will be selected, with staggered tenures of 2 and 3 years.

Applicants were sought who have a wide interest and broad experience in mental health in the Capital Regional District from one or more of the following perspectives: users/consumers of mental health services, family members or other support systems, practitioners/professionals, either institutional or community-based, or members of boards or advisory groups involved in issues or services related to mental health.

Using selection criteria described in Chapter 3, the applications will be reviewed and recommendations will be made to the Capital Health Council on Coalition membership. The Capital Health Council will select the Mental Health Coalition members once the additional members have been appointed to the Council by the Minister of Health.

Following the appointment of the Coalition members, a strategic planning session will be held to allow the Coalition an opportunity to begin developing long and short-range plans and objectives. Among the early tasks of the Coalition will the development of a community consultation and feed-back strategy to ensure that those with an interest in mental health issues in the CRD have an appropriate means of communicating with the Coalition.

3. Mental Health Coalition Focus and Composition

The Mental Health Coalition will bring together the key interests concerned with mental health in the Capital Regional District. Under the direction of the Capital Health Council, it will assist in fostering comprehensive, continuous and coordinated delivery of mental health services.

The Coalition will provide a focus on mental health needs centred around issues drawn from the perspective of the whole community, rather than individual provider groups. It is intended that it will provide direct community access and input from a broad base of consumers, providers and practitioners, building on existing community networks. The Coalition will assist the Health Council in developing consensus around key mental health issues, identifying priorities and developing action plans. It will coordinate with other coalitions where overlapping concerns are identified.

More specifically, it is expected that the Coalition will assist the Health Council in undertaking some or all of the following tasks:

- consult widely with individuals and groups with an interest in mental health;
- investigate and research specific issues relevant to mental health;
- monitor inter-jurisdictional delivery of mental health services;
- initiate demonstration projects, as directed by the Capital Health Council;
- advocate on behalf of community mental health interests;
- advise and recommend to the Capital Health Council on mental health needs and issues.

It is intended that the Coalition will demonstrate the following properties:

- geographic balance;
- gender equity;
- balance between service clients/users and practitioners/helpers;
- a "front line" delivery focus;
- balance among various delivery systems: agency, institutional, private practice, etc.;
- a variety of views of service delivery;
- special interests & needs;
- special perspectives that may come with unique training and experience.

Individuals selected for the Coalition will be expected to demonstrate the following:

- the ability to perform effectively in a team-oriented environment;
- a broad range of experience and/or expertise;

- recent experience in receiving, delivering or coordinating mental health services in the CRD;
- appreciation of the issues related to a coordinated delivery of health services across a number of jurisdictions and disciplines;
- the ability to commit the necessary time to the Coalition.

Chapter 4 provides a summary of information collected, during the consultation process, on community suggestions for system improvements and potential Coalition tasks.

4. Community Identified Needs and Suggestions

During Phase I of the project, consultations with the community identified a great many mental health issues and problems, generating many suggestions on desirable objectives and tasks for the Mental Health Coalition. Some identified problems were specific to one group or individual. However, over the course of the consultation process, it became evident that the problems and issues identified by the community fell within several broad categories.

When asked what objectives and tasks the Mental Health Coalition should undertake, the following were suggestions which came forward from many in the mental health constituency:

4.1 Scope

Many felt that the scope of the Mental Health Coalition's attention should be as broad as possible, from prevention to care for the chronically mentally ill. A number of persons felt that social issues such as drug and alcohol abuse and sexual and physical abuse are inter-related with issues of mental health and can not be ignored when considering mental health services. At the same time, there was strong support for the idea that the Coalition, while working within a wide scope, should have a clear focus on the needs of the chronically and seriously mentally ill, including those suffering from schizophrenia and manic-depressive illness, as well as Alzheimers and dementia. Advocacy systems were also identified as being critical for the chronically and seriously mentally ill.

4.2 Coordination

All institutional and community groups saw the need for the Mental Health Coalition to play a strong role in the coordination of services within the community. There were many references to little or no coordination in the present system, and where it does exist, it is often dependent on informal relationships among individuals. Examples mentioned were a lack of communication between the Eric Martin Pavilion and the Mental Health Centres, the Eric Martin Pavilion and the private psychiatrists, between the Mental Health Centres and the community agencies, between the psychiatrists and the general practitioners, etc. This creates duplications of effort, lack of continuity in care, and tremendous frustration for individuals and families already under great stress. The system is organization-centred rather than client-centred.

Crucial to a coordinated system of care are shared information systems of one kind or another. These are presently non existent, or are based on an informal sharing of information. There is not even one definitive list of available resources. Every agency and group maintains their own. This is costly duplication in a resource-poor system.

4.3 Comprehensive Services

Closely related to coordination, the community indicated a desire that the Mental Health Coalition be involved in planning for comprehensive services within the CRD. Deinstitutionalization has brought into clear focus the lack of comprehensive community services. Areas mentioned as being particularly lacking at the present time include:

1. Adequate community based housing for the mentally ill. Affordable housing is a problem for the general population in the Capital Regional District and is a problem of crisis proportions for the mentally ill.

2. Community based emergency services offered on a 24 hour per day, seven day per week basis. In fact, the times when services are least available are those times when a person with a mental illness is more likely to suffer a crisis — at night, during holidays, etc.

3. Affordable treatment is in very short supply in the CRD. The fact that general physicians can only bill for four counselling sessions per client adds to this problem, as does the fact that psychologists and other certified therapists are not covered by the Medical Services Plan. This makes many individuals dependent on volunteer counsellors and self-help organizations, which may or may not be appropriate, depending on their need. On the other hand, psychiatrists, the only profession covered fully by the Medical Services Plan may not be a cost-effective treatment option for many individuals suffering from emotional distress of varying kinds. A range of treatment options is required.

While there were many other examples of a lack of services, those above were the three that arose in almost all discussions.

4.4 Continuity of Care

Closely related to both coordination and comprehensive services is continuity of care. In fact continuity of care is dependent on both the successful coordination of the client's treatment, and the availability of the necessary resources to allow for continuity. Many groups and individuals spoke of this issue with great frustration. Many seriously ill individuals are falling out of the treatment loop on a regular basis, and then must start from scratch again, too often with an episode of institutionalization.

Many spoke of the potential benefits of a neighbourhood delivery model for the delivery of mental health and other health services. There is a sense that the issues of comprehensiveness, and particularly continuity would be well served by adopting this model.

4.5 System Evaluation

Many individuals and groups pressed for a thorough evaluation of all services presently available in the CRD related to mental health, including institution, mental health centres and community agencies and groups. Many felt that it was not enough to simply look for additional funds to try to deal with the provision of comprehensive services. Many groups recognized that there is, in fact, duplication of some services while there is a total lack of others. Since there has been no coordinated planning, small non-profit organizations have sprung up over the years to try to fill some of the holes in services, sometimes based not so much on need as the availability of funding for only certain kinds of services. The provision of funds and services based on the political popularity of a cause or issue, and not within an overall plan for services, does the mental health services system a disservice over the long term.

The Mental Health Centres were identified as being critical agencies in the provision of mental health services in the CRD. Therefore, many individuals and community groups suggested that it was very

important that the Mental Health Centres undergo an evaluation to determine their most productive role in the community. Many felt that the resources available at the mental health centres were spread so thin and staff were trying to cover so many bases that it was impossible to provide good client care and at the same time maintain effective communication with other agencies providing services. Many staff from the mental health centres share this concern. In fact at the group meetings with staff of the three Mental Health Centres it was evident that many staff members suffer from stress and frustration. A combination of lack of resources, difficulties dealing with a matrix management structure, communication problems, both internally and externally, and difficulties arising in administering contracts for external services were some of the problems mentioned.

Many community agencies indicated they would welcome an evaluation to determine if they were offering services that were, in fact, effective. Several individuals who work with clients in a residential setting indicated that there should be evaluations of individual client's status on a regular basis, to see if their living arrangements remain adequate to their needs and self-care abilities.

4.6 Funding and Resource Issues

While most individuals and community groups were anxious to see the Mental Health Coalition become involved in recommending on funding issues, this was tied closely to the concerns around evaluation. That is, the community does not want to see the Coalition simply given some input over additional funds without a corresponding thorough evaluation of the cost effectiveness of the current system.

While the majority feel that mental health has been starved for funding for years, they realize that there is no clear indication of where the greatest need is and what is the most cost effective way of maximizing the provision of services. It is not enough to distribute resources based on who is the most organized and the most vocal.

An important issue related to funding is the large differentials in pay scales for those persons performing similar tasks in government or institutional settings as compared to community agencies. The funding levels of community agencies do not allow them to pay their staff wages that even approach those offered in other settings. Needless to say this has led to morale problems and high turnover of experienced staff. High turnover greatly affects system effectiveness and continuity of care.

Differential rates for residential care is also a similar issue, although it appears that the current budget is beginning to address it.

Another issue related to resources and funding is volunteer effort. Many agencies who are completely or partially dependent on volunteer labour are convinced that funding agencies believe that such organizations can get by on almost no funding. Volunteer dependent agencies indicated that funding agencies do not seem to appreciate the funding necessary to adequately train, monitor and support volunteers. Without this support, high turnover in volunteer assistance results, and such turnover can threaten the very existence of the agencies.

4.7 Policy Planning

It was suggested that while important that the Coalition concentrate on service provision issues, it is also important that the Coalition become involved in policy planning. Without the right policies in place to support the provision of services, efforts at coordination, comprehensiveness and continuity will not be successful.

4.8 Bureaucracies

There was a clear warning from the community during the consultation process that the Capital Health Council and Mental Health Coalition must not be simply "add-on" bureaucracies which would add another layer for those individuals or groups who were seeking program support, funding approval or problem resolution. In fact what cynicism was displayed during the consultations was usually around this issue; many were convinced that the addition of the Council and Coalition would only make their lives more difficult. It will be a challenge for the Council and Coalition to ensure that this does not occur.

4.9 Community Input

There was consensus on the need for adequate and regular community input to the planning, funding and delivery of mental health services if the efforts of the Mental Health Coalition to implement some of the above improvements are to be successful. Many individuals and groups stressed that it was important to let the community become part of the solution. This will require effort to empower the community and consumer groups. Indeed it was evident during the consultation process that the Capital Regional District is rich with willing, able and talented people, who, if consulted, have a great many ideas for the solution of problems which may seem intractable at the present time.

One of the important tasks of the Mental Health Coalition will be to provide advise to the Capital Health Council on appropriate structural and administrative mechanisms necessary to coordinate the delivery of mental health services in the CRD. The appropriate structural and administrative mechanisms will be dependent on the unique characteristics of the Capital Regional District, and must provide for an environment that encourages both innovation and diversity.

In an attempt to assist the Coalition in this task, Phase I of this project included an extensive literature search and analysis regarding alternative models for the coordination of mental health services, which have been introduced in other communities. Appendix B presents the results of this analysis. The Chapter includes a section on essential factors for a successful community delivery system. It is encouraging to note that many of those factors are the same as those suggested by the mental health community when giving advice on the role of the Mental Health Coalition and the community.

5. Conclusion

It has been said by one member of the mental health community that "sometimes splendid opportunities come cleverly disguised as insoluble problems." The Capital Health Council is currently faced with what may seem to be a momentous task, but the opportunity is great for real transformation of the mental health care system in the CRD. The emerging Mental Health Coalition has immense potential to mobilize the community around the many and diverse needs of the mentally ill.

In preparing for change, the Coalition should strive to ensure that its structural model for coordination contains the essential components of a successful coordinated mental health system within the context of local community needs. The barriers to implementation, as discussed in Appendix B, are sizable, but not overwhelming, and careful planning can minimize or eradicate most obstacles.

For a coordinated mental health system to work effectively, all components of the system must work in tandem toward the common goal of ensuring the well-being of each mentally ill individual and preventing such illness whenever possible. Mandated or not, such cooperation cannot ensue unless there is a spirit of unity and a willingness to take risks.

Ultimately, quality community mental health care will depend on a response from the greater community which supports and reflects an understanding of and a geniune concern for the anguish and promise of mental illness. Negative stereotypes of mentally ill persons must be replaced by realistic portraits of the mentally ill person as a unique human being with unique needs. There is much to be learned, and much to be shared.

Appendix A

Consultation List

Appendix A

List of Organizations and Groups Consulted during Phase I

Arbutus Society for Children

B.C. Mental Health Society — Emergency Mental Health
Intensive Community Support

Capital Regional District

Capital Mental Health Association

Capital Region Mental Health Advisory Committee

Community Association of Greater Victoria

Community Options for Children and Families

Community Planning Group for the Care of the Mentally Frail Elderly

CoolAid Society

Friends of Schizophrenics

Glendale Lodge

Greater Victoria Hospital Society

Gulf Islands Mental Health Advisory Committee

Intercultural Association

Ministry of Health

Mental Health Centres: Victoria
Saanich
Western Communities

Mental Health Boarding Home Operators

Need Crisis Line

Pacific Centre Family Services Association

Parents in Crisis

Peninsula Community Association

Saanich Peninsula Hospital

Western Communities Mental Health Advisory Committee

Victoria Hospice

Vancouver Island Depressive and Manic Depressive Association

Victoria Medical Society, Psychiatric Division

Victoria Mental Health Residential Program

Victoria Native Friendship Centre

Appendix B

Alternative Coordination Models for Mental Health Delivery

A. Alternative Coordination Models

A.1 Introduction

The delivery of mental health care services has always represented a challenge to those who have assumed responsibility for its implementation and administration. Marginalized and isolated, the mentally ill have not traditionally been a priority in overall health care planning. Recently, the state of the mental health system in the Capital Regional District has come to the forefront as an important issue that must be addressed. The formation of the Mental Health Coalition, under the direction of the Capital Health Council is the first step in addressing this issue.

A focus on an administrative and consultative mechanism to address mental health system needs is a much-needed aspect of mental health policy, but one that has traditionally been overlooked. Much of the modern debate in the field of mental health reflects what Jones refers to pejoratively as ''legalism''; that is, it has focused on the legal *rights* of individuals in the mental health setting, rather than their treatment *needs*.[2] As a result, discussion with respect to administration, management and provision of services has been scarce. Only recently has the importance of the overall system of care been recognized by government. The Seaton Commission Report, ''Closer to Home'', noted that:

> As care for the mentally ill becomes more diverse and complex, accountability for individual assessment and diagnosis, support and follow-up services must be built into the system of care. But while attention is being directed at informed consent and freedom of information issues, the broader question of management and accountability of the system is not being dealt with in any detail, nor will it be addressed given the parameters of the [Mental Health Act] review.[3]

It is this gap in the current review of the *Mental Health Act* that will provide the basis for this paper. The Capital Health Council, with the advice of the Mental Health Coalition, will be attempting to formulate a valid and workable approach to coordinated mental health services. If it is to establish an organizational model that reflects reality, policy, and the distinct characteristics of the CRD, it must be aware of the advantages and disadvantages of various structural models.

With this in mind, the following inquiry will examine alternative organizational models of mental health services coordination, and will suggest the necessary elements of successful implementation. Barriers to implementation will be identified and discussed, and possible solutions will be offered.

The actual case studies referred to in this analysis are based on American models. Community based models in Canada are very recent, and have not been documented in the literature to the same degree. The scope of this phase of the study did not allow the time or the resources to go beyond a search of the current literature on the topic. However, it is recognized that some additional research is required on models of community mental health delivery in Canada.

A.2 The Community Mental Health Movement

Mental health systems in most industrialized countries underwent momentous changes in the decades following WWII. The most significant of these changes was the advent of deinstitutionalization. Like so many terms in the area of mental health policy, deinstitutionalization has been

interpreted in many ways. Aviram has adopted a definition of deinstitutionalization which he claims refrains from ideology or treatment modality; deinstitutionalization refers to "the trends in the discharge of large numbers of patients from mental hospitals into the community and the avoidance of and decrease in hospitalization of mentally ill people."[4]

It was the advent of psychotropic drugs, combined with a realignment of public attitudes, that made it possible to treat mentally ill persons on an out-patient basis in the community. As a result, the last thirty years have seen a decrease in the rate of hospitalization and a subsequent focus on community mental health care. Riverview Hospital, British Columbia's largest mental facility, reached its peak population in 1956 with a total of 4,306 patients.[5] By 1985, Riverview Hospital's patient population had decreased to 1,306.[6]

While hopes were high that deinstitutionalization would improve the dignity and quality of life for the mentally ill, it is generally acknowledged that these hopes have for the most part gone unfulfilled.[7] The shifts in the number and location of patients were not necessarily followed by an improvement in services; indeed, even the most ardent supporters of deinstitutionalization have acknowledged that merely discharging people into the community is insufficient to bring about an improvement in their condition.[8]

Observers seem to agree that a comprehensive system of care in the community is integral to the successful maintenance of mentally ill persons outside of institutions.[9] Yet this system of care has not materialized in the wake of deinstitutionalization.[10] Because mental health services, where they exist at all, tend not to be well coordinated with other services such as housing, transportation, and vocational guidance, many of the chronically mentally ill fall through the cracks of the system, with high rates of rehospitalization, substance abuse, criminal activity and homelessness.[11] Torrey describes aftercare for individuals released from mental hospitals as "a medieval pilgrimage from inadequate housing to crowded outpatient clinics to brief rehospitalizations."[12]

Massive discharges obviously took place in many jurisdictions before quality community care was available, presumably on the premise that "the community" was somehow a more humane environment that "the institution". Boudreau reveals the fallacy of this premise in her examination of the consequences of deinstitutionalization in Ontario and Quebec, explaining that:

> As an hypothesis which needed to be tested, deinstitutionalization was mistakenly understood as a political verity, an extremely convenient truth that needed no verification....We know now, and have known for many years, that deinstitutionalization does not necessarily alleviate patient dehumanizing, that community life is not, by definition, rehabilitative and normalizing, and that the personal, family, and social costs of community care have been grossly underestimated.[13]

While Lamb believes that deinstitutionalization was the correct and humane thing to do, he concludes that it has gone too far.[14] He emphasizes that the mentally ill do not represent a homogenous group; while some mentally persons can be successfully treated in the community, others will require a highly structured and supervised setting for intermediate or long-term management.[15] Lamb explains further:

> Where to treat should not be an ideological issue; it is a decision best based on the clinical needs of each person. Unfortunately deinstitutionalization efforts have, in practice, too often

> confused locus of care and quality of care. Where mentally ill persons are treated has been seen as more important than how they are treated. Care in the community has often been assumed almost by definition to be better than hospital care. In actuality, poor care can be found in both hospital and community settings.[16]

Despite the good intentions of the deinstitutionalization movement, community services have not developed to take the place of the hospital; in fact their absence is an example of "ideology outstrip[ping] reality."[17] Instead of keeping people institutionalized for long periods of time, a similarly inadequate system of care has developed in which patients now revolve in and out of the hospital and prison systems.[18] The American Psychiatric Association estimates a 40 percent prevalence rate for major mental illness among homeless persons in the United States.[19] In Victoria, it was estimated that in December 1989, 200 persons with mental disorders were homeless and living on the streets.[20] In Lightman's view, the actual practice of deinstitutionalization in Canada "must rank as one of the great frauds of our day."[21]

It should be noted that community-based mental health care has not been completely unsuccessful. Stein and Test argue that a carefully constructed and monitored community treatment program has both clinical and economic advantages over institutional care.[22] According to Stein, a community-based treatment program "provides clearly superior clinical results, and costs about the same as, or in some cases somewhat less than, the cost of the revolving-door model, which produces poor clinical results."[23] Carefully constructed and monitored programs are rare, however, and in most places, comprehensive care has not developed to take the place of the institution.

Decision-makers are faced with a system in disarray. Boudreau reflects that: "there is no source of ultimate wisdom on the question of design, nor is there any consensus on the best approach. Policy is a question of preference."[24] Unfortunately, the question facing policy-makers right now is one that appears to require both ultimate wisdom and consensus. They are presented with the daunting task of designing a mental health system that can live up to the promises of community-based treatment. Options represent more than a matter of "preference"; they must offer the possibility of a workable model for the delivery of comprehensive and coordinated mental health services.

A.3 Management of Coordinated Mental Health Services Delivery

A. The Role of Management

The phrase "managed health care" is being increasingly heard in the halls of contemporary health administrators, as a demanding public calls for more efficient, responsive and accountable health services. This is particularly evident in the field of mental health, where the failure of deinstitutionalization has become all too real. Bloom considers managed health care to be "an antidote to the unmanaged health care system of the past."[25] Indeed, past mistakes in the management of mental health care are taking on great significance in current mental health policy development.

In this new management environment, mental health administrators and planners have a particularly challenging task as they grapple with a mental health system which is becoming more and more complex. Polcin believes that the rapid rate of change in both management and delivery of services requires a fresh approach from system leaders. He explains that:

> [I]ncreased empowerment, responsibility, and involvement will facilitate increased commitment and motivation. In the place of the old management skills of technical expertise, organizing, planning and coordinating, are a new array of required management competencies: problem solving, understanding group dynamics, communication skills, posing key issues, conflict resolution, facilitating compromise and negotiation, encouraging responsible autonomy, enjoining staff discussion, and inspiring workers toward a consensus of shared goals.[26]

As the problems of deinstitutionalization become increasingly apparent in our communities, it is unlikely that mental health can remain fragmented and disorganized. More and more, the larger questions will be asked: Who is responsible for the treatment of the mentally ill? What should be the purpose of treatment? Polcin's above strategies for addressing the management needs of an evolving mental health system should be kept in mind as the Capital Health Council and the Mental Health Coalition search for the best manner in which to serve the mentally ill in Victoria.

B. The Need for Coordinated Services

The CRD is struggling with a fragmented and uncoordinated system of mental health care delivery. There has been no community-based central planning or coordinating body, resulting in little communication or cooperation among various agencies. Moreover, there is no tracking mechanism to follow patients as they progress through the system. As a result, it is exceedingly difficult to monitor the continuity and quality of services. This lack of defined responsibilities has become a major issue; CRD community members have voiced their dissatisfaction with the problems of accountability and duplication of services.[27]

Lack of coordination has been identified by Stein *et al* as a key impediment to the delivery of comprehensive mental health services: "Just having a collection of different programs that provide different services is not enough to have an effective system of care. A system of care must organize these services to bring together the patients, and the services to meet their needs."[28] Yet for decades, mental health services have been isolated not only from each other, but also from other health care services and programs. Such fragmentation has consequences beyond inefficient and inadequate services; it reinforces the stigma of mental illness and its alienation from other health problems and treatment services.[29] It also results in the proliferation of specialized program labels and definitions. According to Waizer, "it has become difficult for those attempting to develop a coordinated services system to even understand the existing system, much less improve it."[30]

Waizer's statement echoes the frustration and anger experienced by care-givers, consumers and families in Victoria.[31] Certainly, coordination represents a challenge, but most observers agree that a coordinated mental health service system is a necessary response to fragmented services, allowing for better use of scarce resources.[32]

C. Integration vs. Coordination

While there seems to be little debate over whether coordination is a desirable goal for a mental health system to pursue, a major dilemma in determining an appropriate structure and process for mental health care delivery rests in the confusion and disagreement about terms of reference.

"Integration", "unification" and "coordination" appear frequently in the literature, often interchangeably, and yet they evoke very different connotations, both positive and negative, for different individuals.

It is generally accepted that some degree of integration is desirable among agencies providing services for the mentally disabled.[33] However, researchers rarely define the particular type or level of integration that is being advocated or criticised. Instead, integration *per se* is seen either as good or bad, not as something that works or does not work in a particular circumstance. This may seem like mere semantics, but for any jurisdiction attempting to implement a new mental health structure, the starting point should be an agreement among all participants as to the meaning and implications of important terms of reference. As Jones explains: "One does not ask 'Is integration good?' or assert that it is. One asks, 'Is *this* kind of integration meaningful — at the cost of destroying some other kind of integration?'"[34] In essence, planners and evaluators should not be asking themselves "Is this good in some absolute sense?" but "Does this *work*?"

Coordination, then, rather than representing something better or worse than integration, should be seen merely as a type or degree of integration. By definition, all systems require some linkage among system components. As Jones explains: "Much of the art of administration consists of breaking down larger units into smaller, socially meaningful units, and then finding some suitable means of coordination between them."[35] It is unnecessary, then, to determine whether or not a coordinated mental health services system represents a desirable objective — it does. Instead, what needs to be explored is the kind of structural mechanism which will constitute a "suitable means of coordination."

D. A Definition of Coordination

It remains necessary to develop a workable definition of "coordination" beyond merely "a type of integration". According to Warren *et al.*, "Coordination involves a process of concerted decision making or action in which two or more organizations participate with some sort of deliberate adjustment to one another to achieve a common goal."[36] It should be noted that this definition does not equate coordination with cooperation. Goering and Rogers explain:

> Cooperation, collaboration, competition and conflict are all patterns of interaction which can initiate and sustain coordination. It is also important to consider coordination as a process rather than a product, so that one does not fall into the trap of confusing social structures with the activities they are meant to facilitate. The establishment of a formal mechanism for coordination does not mean that coordination exists. It is the ongoing actions and decisions of those who participate that will determine the extent to which coordination occurs.[37]

The message of this last point is crucial; for coordinated services to *remain* coordinated, the various components which comprise the system must make coordination a priority of the system as a whole.

E. Benefits and Costs of Coordination

The first and most necessary benefit of any coordination effort is improved service to clients. However, it is important to realize that the benefits of improved service alone will not sufficiently induce full cooperation from the various agencies and organizations involved. Incentives must be

offered which appeal to the selfinterest of the participants, assuring them that coordination will not threaten the continued survival of their own organizations.[38] Initially, it will probably be very difficult to convince participants in a newly coordinated mental health system that there are benefits which will offset the loss of power and autonomy. Communication efforts and gradual implementation will be essential in persuading participants that the promise of the unproven is more appealing than the fear of the unknown.

A second potential benefit of coordination is the more efficient use of resources. But as Goering and Rogers observe: "Too often in the past, coordination endeavours have only resulted in a request for more funds."[39] They stress that unless efforts are made to use existing resources more efficiently and effectively, "the long-term viability of any coordinating mechanism during these times of economic restraint is questionable."[40]

The most obvious cost of a coordination effort will be the expense of establishing a new mechanism to coordinate mental health care, since additional staff and time will be required. Theoretically, this cost should be made up over time through savings resulting from increased efficiency, although as noted above, the reality may not live up to the ideal.

For existing agencies, there are costs associated with the loss of autonomy and flexibility. However, perhaps the greatest cost of any coordination effort is time. According to Goering and Rogers, insufficient time is the reason most frequently given to explain resistance to coordination efforts.[41] This again suggests the need for gradual implementation.

Though most observers seem to feel that the benefits of coordination outweigh the costs, Bachrach and Lamb warn that coordination efforts might overshadow efforts to address real delivery issues. They comment that:

> Certainly, successful integration of discrete services into a rational and well-coordinated system could potentially serve the patients who comprise the target population of deinstitutionalization. But perhaps much of the focus on integration is misplaced. Too much emphasis on a goal that has proven so elusive may well represent a diversion from the real problems that face the service system....There is an inherent danger of being seduced by the bureaucratic perspective that almost any problem can be solved if only we make service agencies more willing to cede their territory.[42]

Goering and Rogers agree that it is not inevitable that the benefits of improved and more efficient service to clients will exceed the costs of coordination. They emphasize the need to monitor the coordination process and evaluate its effectiveness.[43]

F. Which Functions should be Coordinated?

Most service organizations typically have planning, administrative and direct service functions. Commonly, coordination efforts focus on the planning function, thereby limiting participation in coordination to personnel at the decision-making level. However, restricting the focus of coordination to this function and level of administration can limit the benefits that can be achieved.[44] Goering and Rogers suggest that the building and maintenance of any system of service coordination "begin with and remain closely tied to the identification of real problems that directly affect clients and front-line workers."[45] They claim that organizations which have

attempted coordination strategies from the "bottom up" report that it is a much more effective strategy for change than those which have attempted coordination from the "top down".[46]

G. What should be the Target Population of Clients and Services?

A key element of a coordinating mechanism is a well-defined target population.[47] It is frequently suggested that coordination efforts target primarily the chronically or severely mentally ill.[48] This population has been seriously underserved in the community health movement, and merit prioritization in any reorganization of mental health care. Focusing on the severely mentally ill does not mean that other mental health issued need go unaddressed; it only means that a coordinating body must undertake to prioritize its activities.

As noted by Goering and Rogers, it is much easier to define the target population of clients than it is to determine the services and agencies which are to be coordinated. They warn that while too large a membership can prevent a coordinating group from functioning, if the coordinating mechanism is to be perceived as effective and legitimate, it must have a broad base of representative services. Moreover, planning and constituency building processes must extend beyond mental health service providers to consumers and families.[49]

A.4 Alternative Structures to Coordinate Mental Health Services

A. Structural Areas

The appropriate structure for a coordinating mechanism is a difficult issue to address. The literature provides more information about what does not work than examples of what does.[50] Nevertheless, Goering and Rogers identify three areas of structure which might form the bases for coordinating mechanisms.

1. Voluntary vs. Mandated

This aspect of structure addresses the organizational rules with respect to participation. Mandated coordinating structures have laws or regulations which impose participation on various groups and services, whereas voluntary structures neither impose nor sanction participation. While early studies advocated voluntary structures, Goering and Rogers note a current trend toward recognizing the importance of a mandate in determining the nature of relationships and interactions among participants of a coordinating mechanism.[51]

2. Formalized vs. Ad Hoc

This aspect of structure defines the relationships among participants. Formalized relationships use contractual agreements to specify the roles and activities of participating organizations, while ad hoc coordinating structures rely on ongoing negotiations and implicit understandings.[52] The certainty associated with formalized structures represents a significant advantage, although ad hoc structures offer more flexibility.

3. Autonomous vs. Dependent

This aspect of structure defines the relationship between the coordinating body and participating organizations. An autonomous coordinating structure is likely to be a separate and visible organization with power of its own. In a dependent structure, on the other hand, final decision-making authority remains with the member organizations.[53]

B. A Continuum of Coordinating Structures

Goering and Rogers, employing the different variables discussed above, conceptualize coordinating mechanisms in four different models. While each has its flaws, these models offer a useful starting point for reviewing the structures that have been employed in a variety of jurisdictions.

1. Entrepreneurial Model

This model involves minimal structuring of interorganizational relationships. Organizations act primarily in their own interest, and interact only in a voluntary, ad hoc fashion. Power and authority remain with individual participants.[54]

There are no case studies of this model, although it is likely the most common "structure" in mental health systems. Essentially, this is the structure (or non-structure) that has existed in the CRD for decades. Some coordination takes place informally, but there has been no mandated authority for organizations to participate in a central coordinating mechanism.

2. Coalitional Model

This model involves the voluntary interaction of organizations with only limited degrees of commitment to a coordinating structure.[55] Goering and Rogers claim that coalitional models of coordination seem to be most effective in terms of the coordination of planning functions.[56] But the absence of a clear mandate from an external authority and the completely voluntary nature of member agency participation limit this model's effectiveness. While a coalition is well suited to facilitation of communication among agencies, it lacks the authority required to resolve disputes between competitive agencies with dissimilar goals.

Case Study: Metropolitan Toronto

An example of a coalitional model is Metropolitan Toronto's Community Resources Consultants (CRC), a demonstration project funded by the Ontario Ministry of Health in 1974.[57] The model was intended to provide a unifying agent to help forge a network out from separate community programs and facilities.[58]

CRC, developed by representatives of 29 psychiatric treatment and rehabilitation facilities in Metropolitan Toronto, was designed to monitor the changing patterns of community programs, facilitate easy and appropriate access to them, identify gaps in the service network, and catalyze the development of new services.[59]

The project basically operated as a central referral agency, advising professionals and community members on the postdischarge placement of mentally ill patients. But during the 39 month demonstration period, only about 23 percent of the recommendations resulted in actual placement of the patients.[60] The low rate of placement was attributed primarily to three factors: 1) the inherent problems of creating discharge plans for the severely disabled; 2) the lack of education on discharge planning in professional training programs; and 3) the lack of availability of appropriate facilities.[61]

While CRC may not have lived up to its hopes of becoming a comprehensive central coordinating body, it did seem to have a remarkable degree of support and cooperation from mental health agencies and services in the community.[62] This high level of cooperation may have resulted from one of several factors. First, the apparently strong leadership of CRC staff seemed to instill trust and confidence in the agency's coordinating abilities. Secondly, the voluntary, independent nature of the agency allowed organizations to make use of its coordinating services without being bound by its decisions. Ultimately, the cooperation of participants may be attributed to the fact that CRC did not undertake more controversial functions such as system planning and resource allocation.

3. Integrative Model

This model entails the formation of a new supra-organization which essentially governs the activities of member organizations and has authority to make binding decisions.[63] While integrative models seem to be more effective in coordinating direct service and administrative functions, these structures are very difficult to establish, particularly where the imposition of such a structure would dramatically change the existing power relationships within the system. To successfully implement a coordination structure based on the integrative model, there should be a well-defined mandate, supported by specific legislation and adequate funding.[64]

Case Studies:

i) Dane County, Wisconsin

Perhaps the most noted and successful example of an integrated model of mental health service delivery is the system established in Dane County, Wisconsin. Since 1974, each county in the state has had a legislated responsibility to plan and provide or purchase necessary mental health services.[65] The intended effect of this legislation was to place responsibility for developing and coordinating mental health services on one county agency, and to allocate funding to community-based programs. With a legislative mandate and the support of the community, Dane County has developed a comprehensive system of mental health care in which 17 percent of mental health dollars are allocated to inpatient care while 83 percent supports community alternatives to hospitalization.[66] This system has been studied worldwide as an exemplary example of a comprehensive and integrated mental health care system.

The centre of the Dane County model is the Crisis Resolution Service (CRS), which acts as a central information bank and as the gate-keeper for all county funded hospitalization. CRS will only authorize payment for hospitalization if a community-based treatment plan cannot be developed. When hospitalization is authorized, CRS continues to stay involved during the period

of hospitalization, monitoring the status of the patient in the hospital, and developing a feasible community-based plan.[67]

Every patient entering the mental health care system has a case manager or case management team that is responsible for planning, coordinating and assessing that patient's treatment. According to Stein *et al.*, the coordination of services has been very successful.[68] Problems with the system have been noted, however, most significantly being the lack of indexing funding for inflation. As a result, the actual level of funding for the system has decreased.[69] The system has also been criticized for its overreliance on community programs; Torrey and Wolfe suggest that hospitalization services may be underutilized.[70]

ii) The RWJ Foundation Program on Chronic Mental Illness

A recent experiment in integrative models of mental health services delivery has been undertaken by the Robert Wood Johnson Foundation. Nine U.S. cities were selected to participate in this demonstration project, which began in November 1986.[71]

The initiators of the project observed that the typical system of care has for years included a variety of providers, but no one entity has been bearing an ultimate responsibility for meeting the needs of chronic mentally ill individuals. Each city participating in the project was therefore expected to create a central mental health authority which would represent an organizational locus of responsibility for the care of the chronic mentally ill.[72] Goldman describes the early vision of these central authorities:

> [Each] mental health authority is a new or existing public or private organization that holds a fiduciary responsibility to assure that the mental health and some social welfare needs of the chronic mentally persons living within its jurisdiction are met. The authority accomplishes this objective by centralizing administrative, clinical, and fiscal responsibility. The mental health authority assumes responsibility for planning, delivering, and overseeing services for chronic mentally ill persons (administrative authority), for setting clinical policy and monitoring clinical performance (clinical authority), and for making fiscal decisions and controlling the financial resources for providing mental health services to its community (fiscal authority).[73]

Perhaps it should not be surprising that such ambitious goals have not transpired in any of the project sites. Initial observations indicate that creating or designating a central mental health authority is an activity which requires a lengthy timespan for implementation. In the RWJ study, most of the sites needed over two years to establish a functioning, centralized mental health authority. And even with a central authority in place, by the third year of the program, no site had developed a truly comprehensive system of care.[74] More significantly, the experience of several sites suggests that "creating a new organization or using an existing organization in a new way can be counterproductive."[75]

It is apparent, then, that while integrative models strive to achieve important and desirable goals, often the rate of progress is less than that envisioned at the initial stage of implementation. A lesson from the RWJ project is that resources and qualified personnel must be in place *prior* to the implementation of an integrative model; they should not be assumed to be *by-products* of integrated services.

4. Federative Model

A federative structure requires an official mandate from a provincial or municipal government, which defines the roles and responsibilities of a coordinating structure. The responsibilities of participating organizations are also laid out clearly in formal agreements.[76] The process of negotiating agreements is crucial to the success of the federative model, since, as Goering and Rogers explain, it "clarifies misunderstandings and encourages each organization to define its expectations and make a commitment about future action."[77] Federations offer an attractive compromise between voluntary and mandated structures; they permit formal planning and structured decision-making, but the locus of authority remains with the member organizations, since major decisions are subject to ratification by member organizations.[78]

It is vital to note, however, that while participants retain a good deal of autonomy, a federative model cannot work effectively unless member organizations are willing to tolerate a certain amount of uncertainty and loss of control.[79] Participants must be convinced that any losses in independence will be outweighed by increased access to political power and decision-making.

Case Study: Georgia

In 1973, interested leaders in the mental health community in Northeast Georgia organized themselves as the Northeast Georgia Mental Health Consortium.[80] Membership consisted of local mental health directors, although there seems to have been participation by community members outside of mental health centres. Relationships among the various components of the mental health system were spelled out in written agreements. For example, bylaws of the consortium specified that case ownership would remain with local community programs, even when patients were hospitalized at regional hospitals. Moreover, regional hospital admission could occur only by referral from a community program. The bylaws also specified that the severely and chronically mentally ill would be given first priority for services. Miles claims that simple contracts like these were sufficient to coordinate services and establish a single point of accountability.[81]

Unfortunately, the system which initially proved so promising in Georgia collapsed within five years due to professional rivalries, inadequate reporting systems and inflexibility of resource allocation.[82] The subsequent apathy and demoralization is typical, suggests Miles, "of those community and state mental health systems where there is highly centralized state management, but no model for the service system it attempts to create."[83] The Georgia project illustrates that a federative model can be successful, but that certain components of the system must be planned for in advance.

5. Summary

Whatever model is selected, perhaps the most important message to gain from the case studies is the recognition that a successful model *program* does not make a successful model *system*. Bachrach explains the importance difference between programs and systems:

> Systems have to serve all in need, not only those who fit in with some predetermined experimental aims. Systems must serve even those who show little hope of improvement. Although model programs can focus their resources on selected patients, mental health systems have to deal with competition from different kinds of patients, and while mental

> health systems must account to governing bodies like legislatures, a model program's primary responsibility is to the controlled testing of an innovative approach....Although [model programs] have been important to the development of principles of programming...they do not, in any sense, provide the global answers that are needed to solve the problems of deinstitutionalization.[84]

It is important, then, that communities refrain from attempting to transform a model program which has succeeded in another jurisdiction into a model system for their locality. Instead, a strategy must be developed to "translate model-derived knowledge into systems-related action."[85] In developing this strategy, it is first necessary to identify and describe the key factors of a successful coordinated mental health system, and proceed to construct the appropriate model around these components.

A.6 Implementation of a Coordinated Mental Health System: Essential Components

If coordinated mental health care is to succeed in the CRD, the planning and development process must carefully consider all the necessary elements of the proposed system prior to implementation. The literature suggests that there are essentially 12 basic components that are integral to a successful coordinated mental health system. While the balance and emphasis on different components will depend to a large extent on community circumstances, each component should in some way be reflected in the overall structure of the CRD model.

A. Central Authority

For coordination to be truly effective, there should be a central authority with a mandated responsibility for the overall planning, administration and coordination of the local service system.[86] This would entail ensuring that there is effective agency coordination, that patients are monitored as they progress through the system, and that treatment continues for each individual patient for as long as is required.[87] A central authority does not mean centralized at the ministry level, but rather centralized in the community, with local involvement and direction. Each community "central authority" would act as the single point of entry into the mental health system for that particular area.

The greatest advantage of a central health authority is that it provides local decision makers with the power to control the most important functions of planning, administering and delivering mental health services. Lehman notes, however, that there are risks associated with central mental health authorities. If an authority lacks the resources or energy to effect change, it may become merely "a passive conduit of funds or, worse, yet another layer of bureaucracy with which providers must deal."[88] While such risks are real and merit consideration, they are by no means inevitable, and do not outweigh the benefits of a central authority. Test and Scott agree that "if community care is to be effective, it is essential that responsibility for the care and treatment of patients rests with a single entity."[89]

B. Cultural Relevance and Specificity

Bachrach points out that a successful mental health system must be tailored to conform to the local realities of the community in which it is located.[90] Successful mental health programs are not noted for their transportability.[91] Thus it is essential that any organizational model be based on local community circumstances, taking into account the historical roles and prior linkage experiences of existing agencies. Factors to be considered include the differences among agencies and participants with respect to size, structure, philosophy, mandate, negotiating skills, and the perceived risks and benefits of coordination.[92]

C. Strong Leadership

It has been noted that in the field of mental health administration: "There is no substitute for good leadership."[93] Indeed, in all successfully implemented coordinated health care systems, leadership appears to be an integral component. Most importantly, leaders must accept that a system-wide structure of power, funding, communication and therapeutic style is in the best interests of the whole system, even if such a structure requires certain concessions from different subsystem components.[94]

D. Multidisciplinary Approach

In a sense, the success of this component depends on the existence of strong leadership, which can facilitate the suspension of professional-identity claims. Most mental health workers will agree that this is an especially large hurdle to overcome, and yet it is essential to the successful coordination of services.[95] A coordinated mental health system must accommodate individual differences of emphasis in therapeutic philosophies, and it must promote acceptance and support of different disciplinary roles.[96]

E. Multiple Patterns of Communication

Coordination is impossible without effective multiple channels of communication both vertically and horizontally throughout the system.[97] The most important, and probably the most difficult aspect of effective communication is the establishment of informal relationships.[98] Cooperation and trust is more likely to evolve from everyday informal interaction than from official meetings.

At the same time, however, formal lines of communication are critical to a coordinated system of mental health care. The traditional reliance of mental health practitioners on referral and interagency communication, while necessary, has failed to achieve coordinated and continuous services for patients.[99] Goering and Rogers stress that local efforts and achievements will be undermined without the establishment of parallel mechanisms for inter-organizational communication and coordination at higher administrative levels.[100]

F. Case Management and Continuity of Care

The central authority should be responsible for the care of all patients within its jurisdiction; this responsibility includes the assignment of patients to a case manager or a core service team immediately upon entry into the system. Case management responsibilities include either providing

needed services, or contracting for services with another agency.[101] Such individualization of treatment has been markedly absent from most community mental health systems in the past, with the result that many patients have been "dumped" into the community without consideration for their specific needs.[102]

Contracting is a major issue in the provision of effective continuity of care. Stein *et al* advocate contracting for services rather than providing them, thereby leaving the central authority free to concentrate on policy issues.[103] Paulson, however, warns of the dangers of abuse in contracting for human services, noting that the difficulties in specifying outcomes and measuring efficiency and effectiveness make the creation and monitoring of contracts problematic.[104]

There is certainly some truth to this statement, but monitoring effectiveness in mental health represents a dilemma regardless of the body which is delivering services. As Keepers and Dunn inquire: "Is an agency bound by contracts and monitored by its independent citizen board harder to police than an underfunded state hospital whose administrator has cronies throughout the state bureaucracy?"[105] In the end, contracting out services or providing services will probably be a policy and manpower choice on the part of the central authority. It should be acknowledged, however, that monitoring contracts to ensure continuity of care will be a sizable, and probably expensive, activity.

G. Chronic Patients Targeted

The chronic mentally ill are often seen as the greatest victims of the deinstitutionalization movement.[106] Transferring responsibility for the care of the mentally ill to the community has resulted in increasing marginalization of the severely mentally ill. According to Bachrach, because the community mental health movement has tended to focus on the "worried well", a successful system of comprehensive and coordinated mental health care must place its highest priority on the chronic mentally ill.[107]

H. Training and Education

For a coordinated system of care to be truly effective, all system participants must be informed about the underlying philosophy and components of the system. According to Test and Marks, training is required which is "truly interdisciplinary, encouraging role expansions rather than turf guarding and argument over who is responsible. All disciplines need to be prepared, trained and encouraged to take more responsibility for the difficult work involved."[108] Consumers, clients and community members should also be involved in educational and training sessions to enhance ownership and commitment to the system.

I. Community Orientation

Clearly, for a coordinated system of community mental health care to be successfully implemented, it must have the support of the community in which it is to operate. Basic to achieving such support is citizen participation in program planning and decision making.[109] Polcin advocates the development of administrative and management systems which focus less on controlling and coordinating functions and more on negotiating group consensus.[110] He observes that, "the overriding need of current community mental health systems is to acknowledge,

understand, and involve various affected groups in the planning, decision making, implementation, and treatment process.''[111] Of particular importance is the participation of consumers and their families; obtaining genuine commitment and collaboration from clients necessitates that they feel empowered and responsible for their choices and actions.[112]

J. Flexible Funding Arrangements

For a coordinated system to successfully operate, the central authority needs to be able to control all public dollars and have the power to allocate funds according to community priorities including the funding of hospital services.[113] It is critical that the central authority make funding decisions based on clinical needs, rather than in response to political pressures.[114]

The case studies illustrate that it is imperative that the funding of coordination efforts be legislatively mandated and indexed for inflation, so that services may be sustained over time. There should be a prior commitment to resources on a permanent basis, so that system participants can plan services with a long-term perspective.

K. Accountability

Concerns for accountability are essentially an aspect of overall planning and evaluation, and an accountability mechanism should be built into the system from the start. It should be recognized that there will be opposition to a clearly conceptualized and articulated model of mental health services. Miles explains this opposition: ''Such a model produces expectations for system performance, which in turn produce methods of holding a system's employees accountable for outcomes.''[115] Nevertheless, the public is increasingly holding public agencies accountable for quality and efficiency of service; it is thus unlikely that any system of care will withstand public scrutiny without providing for some sort of mechanism of accountability.

To facilitate accountability, it will be necessary to clearly state the roles and responsibilities of the various components of the system, and the manner in which these components are to be linked and integrated with the system as a whole.[116] An effective method of evaluation, including quality assurance, will be an integral component of any accountability mechanism.[117]

L. Evaluation

Because of the increased need for accountability in the delivery of public services, evaluation represents a critical component of a successful coordinated mental health system. As Tash and Stahler relate: ''Evaluation and management, once supposedly separated and estranged by the rigors of the research design, are now blatantly cohabiting with one another in the mental health system.''[118] Yet while program evaluation is a concept familiar to many in the social services field, Bachrach and Lamb claim that systematic assessment of the community mental health system as a whole has yet to be undertaken.[119] They stress that before a satisfactory evaluation can be performed, there must be an understanding of the sociology of the system and its components.[120]

Bachrach refers to this type of system-wide evaluation as ''impact evaluation'', and explains how it contrasts from more traditional forms of evaluation: ''The difference between impact evaluation

and other kinds of evaluation may be approached metaphorically through the paradox that the operation was a success, but the patient died."[121]

A mental health care system, then, must not merely focus on the results of a particular program or research project; rather evaluation must be a system-wide, ongoing effort to determine whether stated goals and objectives are being achieved. This is more difficult than it appears. It may seem simple enough to set out goals, but the challenging aspect of evaluation in a mental health setting is the dilemma of measuring outcomes. Outcome studies are considered by many to be a controversial form of quality assessment, since mental health system activities are often directed at vague populations and are intended to achieve ambiguous goals that are difficult to assess directly. Thus outcome may or may not be a direct function of service quality.[122] As Zusman explains, "differing outcomes may reflect the nature of the patient and the illness as much as they do the care provided."[123]

For systematic evaluation to be successfully undertaken, information about individual clients, programs, and the operation of the system as a whole must be accessible and available to those who are responsible for monitoring the system. It is imperative to a coordinated service strategy that patients are tracked as they progress through the system.[124] This can be problematic in a legal system which protects the confidentiality of patient records. However, effective quality of care may not be provided, let alone measured, without central data collection and dissemination. Bachrach and Lamb expound the need for an efficient, but noninvasive data system: "In an ideal information system, collecting relevant information on a patient's needs would start at the time of his first contact with the service delivery system. Moreover, information would be compiled and released with no threat to the patient's civil liberties."[125] In an information system which is less than ideal, however, planners may have to be content with ensuring that information is as comprehensive as possible.

A.7 Implementation Issues: Barriers and Strategies

Goering and Rogers offer two warnings with respect to implementation of a coordinated system of mental health: "[First], those who will be affected must be involved in the planning process; and [secondly], it takes time to bring organizations into a new type of relationship. Any attempt on the part of an external authority to introduce an overreaching and rational plan designed to produce immediate service coordination is doomed to failure".[126] With these warnings in mind, it is appropriate to identify and examine some of the major barriers to implementation of a coordinated mental health delivery system. Where possible, solutions and strategies to overcoming these barriers will be discussed.

A. Administrative Barriers

The implementation of any coordinated service system will involve some degree of administrative upheaval. Keeping in mind that "the primary goal is quality of care rather than ease of bureaucracy,"[127] a coordinated service system must nevertheless pay attention to the needs of those who administer the services. Jones agrees that "there is a gap between...meta-policy and the day-to-day running of a mental health service."[128] Jones attributes the inability of the British Mental Health Service to implement a coordinated system its the failure to account for administrative realities. She reflects that "a system which on paper allowed for considerable flexibility between agencies

of equal availability and personnel of equal prestige ran into difficulties of unequal financing, unequal prestige, and the unequal exercise of power."[129]

It is evident that administrative barriers can represent a serious dilemma for planners. Real problems can occur when the shift of administrative and management responsibilities do not accompany changes in service delivery. This mistake is likely in part responsible for the inability of the community health movement to respond adequately to the needs of discharged patients; even after deinstitutionalization, administrative authority tended to remain vested in hospitals.[130]

Yellowlees insists that: "Neither administrative changes nor administrative action will be sufficient on its own [to bring about successful coordination]."[131] This may be true, but administrative barriers on their own *are* enough to limit the success of the system. Klerman thus offers four mechanisms which may assist in overcoming administrative obstacles to the implementation of coordinated services.[132]
First, he suggests the separation of policy staff from program staff. While intraorganizational communication is crucial, a clear definition of roles and responsibilities enables staff to do the job for which they are qualified. Secondly, Klerman recommends the creation of new agencies or organizational components. Thirdly, administrative barriers may be overcome through the use of contracts for the provision of services. Lastly, Klerman suggests a reallocation of existing funding or the creation of new funding sources. This last suggestion, while attractive, is troublesome, since money represents a barrier in itself.

An innovative approach to overcoming administrative barriers has been attempted by New York State.[133] The state has recently developed a "Dictionary of Mental Health Programs" as a planning document. The purpose of the Dictionary is to map out a universally accepted set of definitions and terms.[134] Waizer explains:

> The Dictionary defines each program so that the public understands its service purpose, intent and outcomes...The goal of the Dictionary is to "demystify" the mental health system. It is not an end, but a means to broaden involvement in the public process for those citizens interested in improving services quality and coordination. As a tool, it provides a framework for coordinating the administrative activities of complex governmental structures by providing a common language for certification, licensing, regulation, financing, monitoring and program research.[135]

New York State has wisely and accurately identified the lack of a common language as the root of many policy problems in mental health. Such a "dictionary" makes an excellent starting point for any system attempting to undertake a coordinated system of mental health services delivery.

B. Professional Barriers

A frequently cited barrier to the implementation of coordinated services is the difficulty of overcoming professional resistance.[136] Mental health professionals frequently have extreme differences of opinion with respect to therapeutic style. As Bachrach and Lamb remark, "care givers have a tendency to regard their own services as the least restrictive."[137]

Pessimism abounds with respect to the likelihood of wholly overcoming professional barriers to coordinated services. Coordinated delivery entails a great deal of communication and trust, and many professionals are reluctant to surrender their autonomy. Cooper cautions his colleagues that

"psychiatrists must be wary of large scale changes suddenly imposed from the outside."[138] Bachrach & Lamb are even more sceptical, reflecting that perhaps coordination and integration is not worth the time and energy required:

> It really is time to reconsider the efficacy of placing so much energy in an attempt to bring about integration in the care of the most seriously mentally ill. Perhaps, instead, it would be more appropriate to face the reality that turf problems and territorial concerns do exist and that, because service providers are also human beings with allegiance to a variety of subcultures, they will, even with the best of intentions, be inhibited in their efforts at achieving perfect integration....The emphasis should be less on coordination and integration than on optimal communication and cooperation.[139]

Clearly, professional resistance to coordination represents a difficult situation. Workers must be convinced that there is some benefit available from cooperation; they will strongly resist policy changes imposed from above which give no regard to professional perspectives and experiences. Lehman confirms that incentives must be provided to professionals to secure their compliance with coordination: "If administrative and fiscal reorganizations are to be the sticks of this transition to better care, then training and tangible incentives for front line staff must be the carrots."[140]

Tangible incentives, such as better working conditions and more reasonable caseloads, would certainly improve the motivation and morale of health care workers. But perhaps training and education represent the more significant incentives, since the shortage of trained personnel has been identified as another major barrier to successful implementation of coordinated services.[141] Interdisciplinary education and reciprocal understanding between the professions should be encouraged and provided for. Cooper alleges that there is "a considerable ignorance of the professions about the training and knowledge of each other."[142] He explains the situation as follows:

> It is often found that nurses are teaching psychiatry to nurses, and psychologists are teaching psychiatry to psychologists, rather than these disciplines enroling psychiatric teachers to teach psychiatry....Sadly, it is very unusual to find anybody teaching anything about nursing to psychiatrists (or to any other type of doctor).[143]

The lack of communication and cooperation among disciplines is not aided when Medical Services Plans do not reimburse counselling by psychologists, social workers or nurses. Boudreau agrees that the Canadian health insurance system represents a major barrier to coordinated service delivery, because "by reimbursing only medical care, [it] restricts access to alternatives and thus gives the medical profession a virtual monopoly in care, [guaranteeing] its dominance over the entire mental health system."[144]

Professional resistance to coordination, while substantial, need not prevent a coordinated system from developing. It is crucial that planners ensure broad representation from all disciplines, and solicit their regular feedback to policy changes. Equally important is patience; Cooper claims that it can take up to a generation for a new idea or attitude to permeate the medical profession.[145] Gradual and open implementation will be imperative to successfully meeting the challenge of professional obstacles.

C. Economic Barriers

From a practical point of view, a lack of economic resources may constitute the greatest barrier to the implementation of a coordinated community system of mental health services. Deinstitutionalization was supposed to capture tangible savings in mental health care; in 1987 the *Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital* advocated a plan to reallocate these funds from institutions to the community.[146] Since 1985, however, while the B.C. Mental Health Services Division's budget has been increased to provide community services, neither the budget nor the staff of Riverview Hospital has substantially decreased.[147] The Seaton Report, commenting on the lack of promised savings, explains that:

> Reductions in variable costs, such as the closure of a unit, will not result in major savings. Savings can only be realized by eliminating both fixed costs and variable operating costs. The community system has not been treated as an alternative to the established institution but as an add-on cost.[148]

If community services are seen merely as add-on alternatives to institutions, they will have difficulty competing for an increasing share of the financial resources.

Why has action not followed policy? Bloche and Cournos observe that from a social welfare perspective, community treatment is preferable to institutionalization; but from the fiscal perspective of government, conventional hospitalization offers greater economies of scale. As a result, Bloche and Cournos allege that "the institutional capacity of government to make the socially preferable choice for the chronically mentally ill is in doubt, especially in view of the fact that the mentally ill are in political competition for public resources."[149] Government, like professionals, must be convinced that coordinated community treatment of the mentally ill has benefits that outweigh the costs.

The Seaton Report declares that: "if there is to be further deinstitutionalization, then more money will be needed to fund community services."[150] However, Stein and Ganser claim that there is already enough money in the system to provide good community care, "if only that money were distributed more rationally."[151] Rubin agrees that: "Reducing the [economic] barriers through program design changes will be the easy part of any policy reform. Achieving a sufficiently strong consensus to re-allocate funds from one source to another will be the more difficult task."[152]

One solution to the problem of the "dollars not following the patients,"[153] is to grant more control over funding allocation to local central mental health authorities. Not only is this a potential solution to the dilemma, but as noted above, it is an essential component of a successful coordinated service system. At the same time, however, jurisdictions which have experienced the transfer of financial responsibility to the local level warn of the dangers of decreased funding over time. Treffert shares the experience of Fond du Lac County, Wisconsin:

> [W]hat had been a sum-sufficient state appropriation became a sum-certain state grant for local communities to perform these new mandated services. The transfer of funds was the carrot; assumption of responsibility from what had been state to local jurisdiction was the stick. The state, with local mandates firmly in effect, continued these mandates but generally reduced the funds by not allowing inflationary increases for local programs...While the dollar may be following the patient, dollars have not been following dollars.[154]

Evidently, if control over financial resources is to be transferred to a local authority, this transfer must be accompanied by a guarantee that provincial funding will be maintained at levels sufficient to meet existing and potential community needs. Of course, such a guarantee about public monies has major political consequences. And as Hoult attests: "A program of major change will never succeed without political will."[155]

D. Political Barriers

The RWJ study indicates that, to be properly effective, central authorities need a political mandate. While there has been much focus on the structural and organizational nature of such an authority, Rosenberger supports the notion that "the carrot alone will not work. This is a political issue, not an organizational problem, and it requires a political solution."[156]

Rosenberger's comment may be valid, but the fact remains that, historically, political commitment to mental health issues has been mediocre, where it has existed at all. It should not be surprising that the mentally ill are ill-served by the political system. The mentally ill simply lack the constituency and capacity necessary to effect majoritarian reform.[157] Rubin further explains this lack of political interest in community mental health care:

> The reality of the situation is that only a small minority of the public directly benefit from more organized and coordinated community care for the mentally ill. Thus, there is a need to tackle a task which could disadvantage some persons, through higher taxes, to benefit a relatively small number of people. The circumstances do not constitute a particularly attractive political situation. In a sense, even if the economic benefits and costs end up favouring community-based systems of care, the distribution of benefits and costs, with its political implications, may deter the widespread implementation of innovative community mental health care.[158]

There is clearly a dilemma in imposing community care on a public unwilling to accept its costs. As Boudreau succinctly points out: "how can a government impose mutual help on a collectivity, a voting collectivity!"[159]

An answer to this dilemma may lie in changing the manner in which mental illness is depicted by policy-makers. According to Bloche and Cournos, the typical caricatures of mental illness in public policy "have rationalized abdication."[160] The essence of their argument is that characterizing mentally ill people as criminals or nuisances has provided a means of disconnecting the public from the reality of the individual situation of the mentally ill person. A focus on commitment criteria, for example, suggests that mentally ill people must be coerced into treatment. Bloche and Cournos believe that this type of portrayal "invites policy-makers to withdraw from the work of developing comprehensive community treatment and support programs capable of engaging patients."[161]

The ultimate solution to these political barriers, then, will rest in the education and mobilization of the public to respond to the needs of mentally ill persons in the community. Fortunately, there are increasing signs of recognition among the general public that mental illness is not a choice, but a tragedy, and an issue that concerns society as a whole.[162]

E. Legal Barriers

Law and mental health have long experienced a tenuous and often bitter relationship. The legal perspective of mental illness tends to focus on the protection of a patient's legal rights; the medical perspective, on the other hand, tends to see the law as a potentially annoying interference in the quest for treatment.[163] Yet the law and the mental health system are very much intertwined, as Unsworth explains: "Law actually constitutes the mental health system, in the sense that it authoritatively constructs, empowers and regulates the relationships between the agents who perform mental health functions."[164] It should not be surprising, then, that the law represents possibly the greatest barrier to implementation of a coordinated mental health system, and at the same time offers the greatest solution to overcoming all other barriers.

In most countries that have undergone a shift from institutional care to community-based treatment, the present law does not reflect the changes in mental health policy.[165] Gordon and Verdun-Jones confirm that in Canada, "little attention has been paid to the need to harness mental health law in the service of a campaign to combat the tragic fallout from the intertwined policies of deinstitutionalization, non-institutionalization and privatization."[166] Curran and Harding acknowledge that although there are substantial advantages in leaving details to non-statutory policy instruments, such a total absence of statutory or regulatory provisions has resulted in a lack of specific accountability to the public through the legislative and political system.[167]

This lack of accountability of the mental health system has been identified as a significant issue in the CRD. While the B.C. *Mental Health Act*[168] sets out the responsibilities of mental health facility directors with respect to institutionalized patients, it does not address the larger issue of responsibility for the system as a whole. It is impossible for stakeholders to glean from the *Act* just who is ultimately responsible for the care of the mentally ill.

Shah has proposed a model for incorporating the machinery of accountability into mental health legislation.[169] He suggests that five basic questions be asked by legislative planners:

1. What are the fundamental societal values to be protected, goals to be attained, or social harms to be avoided under the law?
2. How clearly have these objectives been articulated in the statutes and regulations in order to facilitate their implementation?
3. Have the necessary and appropriate resources to accomplish the objectives been allocated?
4. Have appropriate and effective provisions been made to monitor the programme and to evaluate it periodically in order to facilitate accountability?
5. Have appropriate sanctions been provided to encourage compliance and to discourage and punish noncompliance?

Regulatory design has only recently allowed for such thorough advance planning, which allows legislators to examine *prior* to implementation the actual needs of the system for which the legislation is being enacted. This is a welcome development, although the mental health field obviously has a way to go in this area, since accountability and management issues are not within the purview of the current *Mental Health Act* review.[170]

Curran and Harding warn that if these issues are not considered in future legislative design and review, "new codes will continue the past concentration on inpatient care, perhaps reflecting new concepts of the rights of inpatients, but without realizing that the best way to protect all patients is to afford them a variety of treatment methods suitable to their needs."[171] They provide an excellent framework for comprehensive mental health legislation which embodies all the critical issues discussed throughout this section of the Report.

There is a question of whether it is realistic to expect the government to impose on itself a duty to create and maintain community mental health services. Unsworth reflects that historically, the most striking fact about mental health legislation has been "the single failure of legal provisions to generate new services, falling prey to political and financial pressures."[172] Yet he also notes that recent developments offer promising signs of the possibility of addressing the shortcomings of the mental health system through legislation; Britain's *1983 Mental Health Act* places a duty on district health authorities and local social services authorities to provide aftercare services for certain patients in cooperation with relevant voluntary agencies.[173] Unsworth explains that the *1983 Mental Health Act* reflects the principle of least restrictive alternative, "not only as a libertarian argument for decarceration but also as the basis for a positive legal obligation upon Government to make available the consequentially necessary community alternatives."[174]

Unsworth's enthusiasm for Britain's initiative may be unwarranted. Statutory enactments on a right to treatment are rare,[175] even though it has been over fifteen years since the United Nations General Assembly issued its *Declaration on the Rights of Disabled Persons*, endorsing the right to treatment for all disabled persons, including the mentally ill and handicapped.[176] Some Canadian provinces, including British Columbia,[177]have established a statutory right to treatment for patients admitted to provincial mental health facilities, but this right is expressly limited by the currently available resources.[178]

Significantly, no jurisdiction in Canada has yet established a right to receive mental health services in the community.[179] Gordon and Verdun-Jones strongly advocate for such a right to be established, contending that as legal requirements of commitment laws make it more difficult for mentally ill persons to receive treatment in institutions, "it will be necessary for provincial legislatures to entrench a right to effective mental health services...such a right should include an entitlement to effective treatment in the community, wherever possible."[180] Gordon and Verdun-Jones concede, however, that a broadly conceived right to effective mental health treatment will likely come about only "by generous interpretation of the *Charter*."[181] Such a broad interpretation of the *Charter* is remote; to date, the courts have displayed great reluctance to expand *Charter* provisions to encompass the imposition of positive duties on governments.

Bloche and Cournos believe that constitutional litigation offers little hope of transforming the care of the mentally ill in the community.[182] They suggest that turning to tort doctrine might offer more "room to manoeuvre."[183] Bach agrees that the common law has advantages over constitutional law, explaining that:

> One of the most important features of the common law approach that distinguishes it from other legal alternatives is that it recognizes a *continuing* duty of care that extends beyond the technical termination of the patient's institutional stay and accompanies his or her return to the community. This duty could be employed as an effective legal means for refining the process of deinstitutionalization and for guaranteeing better access to community care.[184]

Essentially this argument would impose a duty on the state to proceed with due care in discharging patients from institutions. In effect, a legal standard of comprehensive community care would be established. Bach concedes that the threat of negligence suits might simply result in reduced access to institutional care. However, he contends that "this possibility, while serious, poses only a slightly greater threat to patients than the status quo."[185]

It is important to note that other obstacles might be more difficult to overcome. As with constitutional rights, judges may be reluctant to extend medical malpractice law to encompass the provision of social services.[186] Financial barriers may also limit the ability of facilities to meet the common law standard. As Bloche and Cournos observe:

> For a facility without overall, mandatory responsibility for organizing and providing services to the chronically mentally ill, cutting back on services may be a more rational response ...than improving services. Alternatively, state facilities might simply decide to pay the cost of liability rather than upgrade their outpatient programs. The ability of advocates for the mentally ill to litigate on a sufficiently large scale to make state agencies liable for all or most of the social cost of substandard outpatient care seems doubtful.[187]

In the end, it seems that legal barriers are difficult to overcome, and legal solutions are not promising. Nevertheless, there does seem to be a greater awareness of and sensitivity to the need for coordinated community services for the mentally ill. There also seems to be a greater demand for government to assume some positive duties with respect to fundamental needs of life, such as medical treatment and shelter.[188]

End Notes: Models for Coordinating Community Mental Health Services

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122. J. Zusman, "Quality Assurance in Mental Health Care" (1988) 39 Hosp. and Community Psychiatry at 1286.

123. Goering & Rogers, *supra*, note 32 at 8.

124. Bachrach & Lamb, *supra*, note 41 at 158.

125. Goering & Rogers, *supra* note 32 at 8.

126. J.A. Talbott, "The Future of Unified Mental Health Services" in Talbott, ed., *supra*, note 41 at 107.

127. Jones, *supra*, note 33 at 12.

128. *Ibid.*

129. Curran & Harding, *supra*, note 28 at 77. The frustration at this traditional power and influence of the hospital was very much evident at the community mental health meeting in Victoria on March 22. The multiplicity of administrative hurdles associated with continuity of care seems to generate feelings of anger and helplessness.

130. Sir H. Yellowlees, "Administrative Barriers to Implementation and Diffusion of Innovative Approaches to Mental Health Care in the United Kingdom" in Marks & Scott, *supra*, note 88, 167 at 177.

131. G. Klerman, "Administrative Obstacles to Innovations in the US at the Federal Level" in Marks & Scott, *supra*, note 88, 179 at 187.

132. Waizer, *supra*, note 29.

133. *Ibid*, at 23.

134. *Ibid*, at 24.

135. J.E. Cooper, "Professional Obstacles to Implementation and Diffusion of Innovative Approaches to Mental Health Care" in Marks & Scott, *supra*, note 88, at 252-253.

136. Bachrach & Lamb, *supra*, note 41 at 153.

137. Cooper, *supra*, note 135.

138. Bachrach & Lamb, *supra*, note 41 at 152-153.

139. Lehman, *supra*, note 87 at 919.

140. *Ibid*. at 916.

141. Cooper, *supra*, note 137 at 248.

142. *Ibid.*

143. F. Boudreau, "Partnership as a New Strategy in Mental Health Policy: The Case of Quebec" (1991) 16 J. Health Politics, Policy and L. 307 at 324.

144. Cooper, *supra*, note 135 at 252.

145. *Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital* (Victoria: B.C. Ministry of Health, 1987)

146. *Seaton Report, supra*, note 2 at c-77.

147. *Ibid*.

148. *Ibid*. at C-78.

149. Bloche & Cournos, *supra*, note 18 at 401-402.

150. *Seaton Report, supra*, note 2 at C-77.

151. Stein & Ganser, *supra*, note 65.

152. J. Rubin, "Economic Barriers to Implementing Innovative Mental Health Care in the United States" in Marks & Scott, eds., *supra*, note 88, 220 at 221.

153. Stein & Ganser, *supra*, note 65.

154. D.A. Treffert, *supra*, note 68 at 34-35.

155. J. Hoult, "Dissemination in New South Wales of the Madison Model" in Marks & Scott, eds., *supra*, note 88, 41 at 48.

156. J.W. Rosenberger, "Central Mental Health Authorities: Politically Flawed?" (1990) 41 Hosp. and Community Psychiatry 1171.

157. J.P. Bach, "Requiring Due Care in the Process of Deinstitutionalization: Toward a Common Law Approach to Mental Health Care Reform" (1989) 98 Yale L.J. 1153.

158. Rubin, supra, note 152 at 230-231.

159. Boudreau, *supra*, note 12 at 40.

160. Bloche & Cournos, *supra*, note 18 at 399.

161. *Ibid.*

162. Jim Compton, *The Compton Report*, KING-TV, Seattle Washington, March 15, 1992.

163. Unsworth, *supra*, note 1 at 4.

164. *Ibid.* at 5.

165. Curran & Harding, *supra*, note 28 at 78.

166. R.M. Gordon & S.N. Verdon-Jones, "The Trials of Mental Health Law: Recent Trends and Developments in Canadian Mental Health Jurisprudence" (1988) 11 Dalhousie L.J., 833 at 863.

167. *Ibid.* at 26.

168. *Mental Health Act*, R.S.B.C. 1979, c 256, s.8.

169. S.A. Shah, "Dangerousness: Some Definitional, Conceptual, and Public Policy Issues" in D.B. Sales, ed., *Perspectives in Law and Psychology*, vol 1 (New York: Plenum Press, 1977)

170. Seaton Report, *supra*, note 2.

171. Curran & Harding, *supra*, note 28 at 79.

172. Unsworth, *supra* note 1 at 15.

173. *Ibid.* at 13-15.

174. *Ibid.* at 15.

175. Curran & Harding, *supra*, note 28 at 56.

176. United Nations, *Declaration on the Rights of Disabled Persons. Resolution* adopted by the General Assembly during its twenty-sixth session. Official Records: Supplement No. 34 (A/10034) New York, 1972, cited in Curren & Harding, supra, note 28 at 55.

177. *Mental Health Act*, R.S.B.C. 1979, c.256, s. 8(1)(a). Alberta and Saskatchewan also provide for a limited right to treatment. See *Mental Health Act*, R.S.A. 1980, c. M-13, s. 13(1), and *Mental Health Services Act*. S.S. 198-85, c. M.13.1, s.27.

178. Gordon & Verdun-Jones, *supra*, note 166 at 836.

179. *Ibid.* at 837.

180. *Ibid.* at 862.

181. Gordon & Verdun-Jones, *supra*, note 166.

182. Bloche & Cournos, *supra*, note 18 at 403.

183. *Ibid.*

184. Bach, *supra*, note 157 at 1161.

185. *Ibid.* at 1169.

186. Bloche & Cournos, *supra*, note 18 at 404.

187. *Ibid.* at 405.

188. The entrenchment of a social charter in the constitution could have a great impact on the services provided to the mentally ill. However, it is debatable whether a social charter will ever gather enough support to find its way into the constitution.

189. Treffert, *supra*, note 68 at 36.

190. World Health Organization, Changing Patterns in Mental Health Care. Report on a WHO Working Group (Copenhagen: World Health Organization, 1980) at 7.

Appendix C

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